433.469: Oxygen and Respiratory Therapy Equipment

(A) Eligible Recipients. For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Division pays for oxygen and respiratory therapy equipment as defined in 130 CMR 433.401. For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(B) Nonreimbursable Services.

(1) The Division will not pay for oxygen or respiratory therapy equipment for recipients in acute, chronic, or rehabilitation hospitals, or in state schools.

(2) The Division will not pay for oxygen or respiratory therapy equipment when prescribed for emergency use or on an "as needed" basis for recipients residing in nursing facilities.

(3) The Division will not pay for respiratory therapy equipment that is investigative or experimental in nature, unless prior authorization from the Division has been obtained.

(4) The Division will not pay for nonmedical equipment or supplies. Equipment that is used primarily and customarily for a nonmedical purpose is not considered medical equipment, even if such equipment has a medically related use. For example, equipment whose primary function is environmental control, comfort, or convenience is not reimbursable.

(5) The Division will not pay for oxygen or respiratory therapy equipment that is not both necessary and reasonable for the treatment of a recipient's pulmonary condition. This includes:

(a) equipment or services that cannot reasonably be expected to make a meaningful contribution to the treatment of a recipient's pulmonary insufficiency; and

(b) equipment or services that are substantially more costly than a medically appropriate, feasible alternative or that serve essentially the same purpose as equipment already available to the recipient.

(C) Prescription Requirements. The purchase of oxygen and the purchase or rental of respiratory therapy equipment are reimbursable only when prescribed in writing by a licensed physician. The oxygen and the respiratory therapy equipment must be furnished by a participating Medical Assistance provider. The prescription must include the following information:

(1) the recipient's name, address and recipient identification number;
(2) the specific identification of the prescribed oxygen and equipment;
(3) the medical justification for the use of the oxygen and equipment;
(4) for oxygen: the prescribed liter flow rate and frequency of treatment;
(5) for respiratory therapy equipment: the frequency of use per day;
(6) the estimated length of time the oxygen or equipment will be used by the recipient;
(7) the location in which the recipient will customarily use the oxygen or equipment;
(8) the physician's address and telephone number; and
(9) the date on which the prescription was signed by the physician.

(D) Purchases and Rentals Requiring Prior Authorization. The Division requires that prior authorization be obtained as a prerequisite to payment for the oxygen and respiratory therapy equipment and services listed below.

(1) Purchase of any of the following requires prior authorization:
(a) respiratory therapy equipment costing more than $35.00; and
(b) gaseous and liquid oxygen provided more than three months after the date of the physician's initial prescription.

(2) Rental of the following requires prior authorization:
(a) gaseous- and liquid-oxygen delivery systems after a rental period of three months;
(b) aspirators after a rental period of three months;

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(c) nebulizers after a rental period of three months;
(d) intermittent positive pressure breathing (IPPB) machines after a rental period of three months;
(e) oxygen-generating devices; and
(f) all other rental equipment.

(E) Requests for Prior Authorization. Instructions for the completion of the prior authorization form for oxygen are in Subchapter 5 of the *Physician Manual*. Before determining the medical necessity of the items or services for which prior authorization is requested, the Division may, at its discretion, require the prescribing physician to submit an assessment of the recipient's pulmonary condition on a patient respiratory evaluation form supplied by the Division.

(1) All prior authorization requests for oxygen and oxygen-generating devices must be accompanied by the results of an arterial blood gas analysis performed within the six weeks preceding the date of the request. This analysis should be performed while the recipient is in a stable chronic condition.

(2) All prior authorization requests for respiratory therapy equipment must be accompanied by the results of a pulmonary function test performed within the six weeks preceding the date of the request.

433.470: Transportation Services

Transportation services are reimbursable only when a recipient is traveling to obtain medical services that are reimbursable under the Medical Assistance Program.

(A) Eligible Recipients. The Division pays for transportation services for Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(B) Service Limitations.

(1) Recipients must use transportation resources such as family or friends whenever possible. When personal transportation resources are unavailable, a recipient must use public transportation, if available in the recipient's locality and suitable to his or her medical condition. Private transportation is reimbursable only when public transportation suitable to the recipient's medical condition is unavailable.

(2) In general, the Division will pay for a recipient to be transported to sources of medical care only within the recipient's locality. Locality refers to the town or city in which the recipient resides and to immediately adjacent communities. However, when necessary medical services are unavailable in the recipient's locality, medical transportation to the nearest medical facility in which treatment is available is reimbursable. If referral outside the recipient's locality is indicated, it is necessary for the physician to supply the recipient's Welfare Service Office with the documentation substantiating this need before authorization can be granted.

(C) Physician Authorization.

(1) Taxi and Dial-a-Ride Transportation. Taxi and dial-a-ride transportation require a prescription written by a physician or dentist on the Prescription for Taxi or Dial-a-Ride Transportation (PT-1) form. (Instructions for obtaining the form are in Subchapter 5 of the *Physician Manual*.)

(2) Ambulance and Chair-Car Transportation. The physician or the physician's designee who requests an ambulance (on a nonemergency basis) or chair car for a recipient must complete a Medicare/Medicaid Medical Necessity form at the time of the recipient's transfer, stating the specific physical disability that necessitates the requested mode of transportation. If the form is not completed by the physician, the physician's name must be entered on the form where indicated and the authority of the designee must be noted.

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Information given on the Medical Necessity form must be supported by the recipient's medical record. Emergency ambulance trips do not require a prescription. However, the nature of the emergency must be supported by medical records at the hospital to which the recipient was transported. (Instructions for obtaining the Medicare/Medicaid Medical Necessity form are in Subchapter 5 of the *Physician Manual*.)

(3) Multiple Trips. When a recipient must travel eight or more times per month to the same destination for a period of two months or more, a physician may authorize all trips for one month (any 30-day period) on one Medical Necessity form. The dates of each trip and the total number of trips must be entered on the form.

(4) Other Forms of Transportation. Other forms of transportation (for example, train, boat, and plane) are reimbursable only if prior authorization is obtained from the recipient's Welfare Service Office or Community Service Area Office.

(D) Recipient Reimbursement. The Division will reimburse a recipient directly for expenses incurred in traveling to reimbursable medical care only if the recipient's physician, registered nurse, licensed practical nurse, or medical facility social worker documents that reimbursable services were received. The documentation must include the following:

(1) the services that were provided;
(2) the date on which services were provided;
(3) the address where services were provided;
(4) the time services were provided, in cases of urgent medical need; and
(5) a statement that the services could not be obtained locally, if the recipient traveled outside his or her locality.

433.471: Therapy, Speech and Hearing Clinic, and Amputee Clinic Services

The Division pays for basic restorative services (therapy, speech and hearing clinic, and amputee clinic services) to reduce physical disability and to restore the recipient to a satisfactory functional level. Only those services that have the greatest potential for long-term benefits are reimbursable. The Division will not pay for medically unnecessary or experimental services.

(A) Eligible Recipients. The Division pays for restorative services provided to Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(B) Physical, Occupational, and Speech Therapy.

(1) Physician Authorization.

(a) Physical and occupational therapy require a written referral from a licensed physician prior to the recipient's evaluation or treatment. The physician's orders for physical and occupational therapy must be renewed in writing every 30 days as long as the recipient is undergoing treatment.

(b) Speech therapy requires the written recommendation of a licensed physician or dentist prior to the recipient's evaluation or treatment.

(2) Service Restrictions. Maintenance therapy is not reimbursable. Only those therapy services that have a specific functional goal are reimbursable.

(C) Speech and Hearing Clinic Services. The recipient must be examined by an ear specialist (an otologist or an otolaryngologist) before referral is made to a speech and hearing clinic approved by the Division. If a hearing aid is indicated, a medical clearance stating that the recipient has no medical conditions to contraindicate the use of a hearing aid must accompany the referral.

(D) Amputee Clinic Services. An amputee clinic provides the following services: complete medical evaluation of the recipient's need for an artificial limb (prosthetic device); counseling concerning the use of the device; prescription of the device; referral to a certified prosthetic company; and follow-up evaluation. The Division will pay for a prosthetic device only when it is prescribed by an amputee clinic approved by the Division.

433.472: Mental Health Services

130 CMR 433.472 describes the range of mental health services reimbursable under the Medical Assistance Program.

(A) Eligible Recipients. The Division pays for the mental health services described in 130 CMR 433.472 for Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(B) Mental Health Center Services. It is appropriate to refer a recipient to a mental health center when the recipient is no longer able to maintain his level of functioning and must seek professional help. Referral for treatment in a clinic setting is appropriate when the individual is not harmful to himself or to others and can maintain himself in the community even if at a diminished level of functioning.

(1) The Division will pay for mental health center services furnished by freestanding mental health centers, community health centers, hospital-licensed health centers, or hospital outpatient departments only when the Division has certified the provider to perform mental health center services.

(2) Mental health center services are reimbursable only when provided by psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, counselors (with a master's or doctoral degree in counseling education or rehabilitation counseling), or occupational therapists.

(3) Mental health center services include diagnosis and evaluation, case consultation, medication, psychological testing if done by a licensed psychologist, and individual, couple, family, and group psychotherapy.

(C) Mental Health Practitioner Services. A recipient may be referred to a private mental health practitioner (a licensed physician or a licensed psychologist) for the same reason that he may be referred to a mental health center. Mental health practitioners provide services that are more specialized and less comprehensive than the treatment and support services provided in mental health centers.

(1) The only mental health practitioners who can receive direct payment under the Medical Assistance Program for diagnostic and treatment services are licensed physicians (*see* 130 CMR 433.428 and 433.429).

(2) The Division will pay licensed psychologists only for providing psychological testing. The Division will not pay psychologists for providing psychotherapy, even under the supervision of a psychiatrist.

(D) Psychiatric Hospital Services. When a psychiatric recipient requires 24-hour management because he may be harmful to himself or to others, or if he is unable to maintain himself in the community, inpatient psychiatric services may be appropriate.

(1) The Division will pay for inpatient psychiatric hospitalization only when provided to:

(a) a recipient 65 years of age or older in a psychiatric hospital participating in the Medical Assistance Program; or

(b) a recipient of any age in a licensed and certified general hospital with or without an inpatient psychiatric unit.

(2) The services of an inpatient psychiatric unit include medication, individual and group therapy, milieu activities, and 24-hour observation provided by an interdisciplinary team.

(E) Psychiatric Day Treatment Services. Some recipients require the structure and support of a psychiatric treatment center, but do not require the overnight care provided by hospitalization. Accordingly, the recipient must have a suitable place to live while attending a psychiatric day treatment program. A psychiatric day treatment program may not adequately meet the needs of actively suicidal, homicidal, severely withdrawn, or grossly confused and disoriented individuals who cannot be maintained by family or friends and who are unable to travel to such a program. The Division will pay for psychiatric day treatment services provided by freestanding mental health centers, hospital-licensed health centers, hospital outpatient departments, or other facilities only when the Division has certified the provider to perform psychiatric day treatment services.

433.476: Alternatives to Institutional Care: Introduction

In recent years, new parts of the Medical Assistance Program have been designed and implemented to help elderly and disabled recipients remain in the community and avoid unnecessary or premature institutional placement. These include home health, adult day health, adult foster care, private duty nursing, independent living, intermediate care for the mentally retarded, and day habilitation. Decisions regarding institutional placement are made by the recipient, his family, his physician, and hospital continuing-care personnel. The physician's role can often be the most influential. For this reason, it is important for the physician to be aware of the alternatives to institutional long-term care. A network of community-based support services that did not exist previously in any quantity or quality is now available in many areas of Massachusetts. Only if physicians become aware of and support the use of such services will the use of institutional services be reduced. For information on services available in your area, contact the Medical Division's Noninstitutional Long-Term Care Unit at the address and telephone number in Appendix A of the *Physician Manual*.

433.477: Alternatives to Institutional Care: Adult Foster Care

(A) Program Definition. Adult foster care is designed to provide a family-like environment for an adult who otherwise would be in a level II or III nursing home. Each foster family may care for a maximum of two participants (elderly or disabled adults). The foster family provides 24-hour supervision and assistance with such activities of daily living as bathing, dressing, and self-administration of medications. Community support is available from such organizations as certified home health agencies and adult day health programs.

(B) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Division pays for adult foster care.

(2) For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(C) Physician Responsibilities.

(1) Each recipient must have medical clearance prior to placement in a foster home.

(2) The recipient's physician is required to provide documentation of the following: a physical examination conducted within the preceding three months; current treatment including medications and diet; and a description of any physical or emotional limitations that may preclude participation in activities.

(3) The physician, with the certified home health agency nurses, must maintain follow-up care of the recipient.

433.478: Alternatives to Institutional Care: Home Health Services

(A) Program Definition. Home health agencies provide health and support services in the home for elderly and disabled persons who wish to remain in their homes rather than to enter an institution. These services are available between 8:00 A.M. and 9:00 P.M., and homemaker/home health aide services are available on a 24-hour or short-term basis. All services are available seven days a week. All home health agencies provide nursing and homemaker/home health aide services; in addition, most agencies provide physical, occupational, and speech therapy. The Division pays only Medicare-certified home health agencies, frequently called visiting nurse associations.

(B) Eligible Recipients. The Division pays for home health services for Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

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(C) Physician Responsibilities. Any physician who believes that a recipient needs home health services should call the home health agency directly or send written orders. A recipient seen by the agency must have written orders from his or her physician; these orders must be updated and recertified every 60 days.

433.479: Alternatives to Institutional Care: Private Duty Nursing Services

(A) Program Definition. A private duty nurse is a registered nurse or a licensed practical nurse who independently contracts to provide nursing services to patients who, without such services, might be institutionalized. The Division will pay for nursing care in the recipient's home when private duty nursing services are less costly than institutional placement, provided that the professional services are medically necessary. This program provides alternative care to those home-bound recipients whose medical and nursing needs cannot be met by a home health agency, adult day health program, or support services.

(B) Eligible Recipients. The Division pays for private duty nursing services for Medical Assistance recipients (catagories of assistance 00, 01, 02, 03, 05, 06, 07, 08) not residing in a hospital or long-term-care facility. For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(C) Prior Authorization Requirements. Prior authorization must be obtained from the Division before private duty nursing services are reimbursable. The attending physician and nurse must document the following: diagnoses, treatment plan, functional limitations, estimated length of service, and description of the recipient's social situation.

(D) Physician Responsibilities. The recipient's attending physician must sign the patient care plan documenting the medical necessity for private duty nursing services.

433.480: Alternatives to Institutional Care: Adult Day Health Services

(A) Program Definition. An adult day health program is a structured program of health care and socialization designed to meet the needs of persons who otherwise might be institutionalized. Adult day health services also enable some individuals who have been institutionalized to return to community living. Adult day health programs are based in a center and may be free-standing or located in nursing homes or hospitals. Staff members of the program make arrangements for transportation to and from the center, depending upon community resources and the recipient's needs. The program offers the participant professional supervision, observation, and preventive health care including medical, therapeutic, restorative, counseling, and nutrition services. In addition, the program offers planned educational, recreational, and social activities. These services are provided to maintain the participant at his or her highest level of functioning, thereby preventing or delaying institutionalization. The program offers the participant's family relief from 24-hour supervision and caretaking. Adult day health programs also provide counseling to family caretakers to help them cope with their family situations.

(B) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Division pays for adult day health services.

(2) For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(C) Physician Responsibilities.

(1) Each recipient accepted into an adult day health program must have a complete physical examination within the three months preceding the recipient's first program attendance day.

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(2) The recipient's physician will be expected to furnish program staff members, upon request, with the results of this physical examination; a list of current medications and treatments; any special dietary requirements; a statement indicating any contraindications or limitations to the individual's participation in program activities; and recommendations for therapy, when applicable.

(3) Each recipient's physician will receive a participant care plan developed by the staff members of the program for review every three months. The program's registered nurse will request that the participant care plan be reviewed and signed by the physician and returned to the program.

433.481: Alternatives to Institutional Care: Independent Living Programs

(A) Program Definition. Independent living programs teach persons with severe physical disabilities the skills to live independently, assisted by a personal care attendant. The skills may be taught in a group residential setting or individually. For those severely disabled persons who have the ability to train and manage a personal care attendant and who are living independently in the community, the program acts as a fiscal conduit to pay the personal care attendant. Participation in this program is helpful to persons to whom a lifetime of institutional or family care is unacceptable.

(B) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Division pays for independent living program services.

(2) For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(C) Physician Responsibilities. The recipient's physician must certify that the recipient is:

(1) severely physically disabled (in need of an average of four hours or more of personal care attendant services per day);

(2) wheelchair dependent for mobility;

(3) emotionally stable; and

(4) medically stable (able to participate in daily living activities without requiring frequent substantial medical care).

433.482: Alternatives to Institutional Care: Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

(A) Program Definition. Community intermediate care facilities for the mentally retarded (or for persons with related conditions) are small community-based residential programs for 15 or fewer residents. There are two types of community ICFs/MR: Type A, serving participants not capable of self-preservation, and Type B, serving ambulatory and mobile nonambulatory participants capable of self-preservation. Both types of facilities provide a planned, 24-hour program of care to persons who are mentally retarded or developmentally disabled. A recipient who participates in a community ICF/MR must be in need of and capable of benefiting from active treatment (for example, a program of regular participation in accordance with an individual plan of care professionally developed and administered by an interdisciplinary team). Treatment is designed to increase the participant's level of functioning and to allow the participant to become as independent as possible. Participants must have the potential through active treatment to move eventually from the ICF/MR into a setting that is less restrictive.

(B) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 0, 1, 2, 3, 5, 6, 7, and 8), the Division pays for ICF/MR services.

(2) For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 4), see 130 CMR 450.111.

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(C) Physician Responsibilities. The propriety of the recipient's placement in an ICF/MR must be certified by a physician at the time of the recipient's admission and recertified every 60 days. The Massachusetts Department of Mental Health regional or area office screens all potential ICF/MR residents. Physicians who believe that their patients are in need of ICF/MR services should contact the Department of Mental Health area office.

433.483: Alternatives to Institutional Care: Day Habilitation Centers

(A) Program Definition. Day habilitation centers serve persons who are mentally retarded and developmentally disabled and who need more habilitative services than are provided in less-restrictive day programs but who do not require full-time institutionalization. Day habilitation centers provide a range of intensive medical, behavioral, and therapeutic services in a culturally normative setting. The centers provide goal-oriented services that help participants reach their highest possible level of independent functioning and that facilitate the participants' moving to less-restrictive settings.

(B) Eligible Recipients.

(1) For Medical Assistance recipients (categories of assistance 0, 1, 2, 3, 5, 6, 7, and 8), the Division pays for day habilitation services.

(2) For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 4), see 130 CMR 450.111.

(C) Physician Responsibilities. The Division screens and refers potential recipients to day habilitation centers with the Massachusetts Department of Mental Health. Any physician who believes that his or her patient would benefit from day habilitation services should contact the Department of Mental Health area office.

433.484: The Massachusetts Special Education Law (Chapter 766)

(A) Requirement of Law. Chapter 766 of the Acts of 1972 is a comprehensive special education law that requires local school agencies to develop and implement individual educational plans for children with special needs. The law mandates that every child between the ages of three and 21 who has special needs should take part in a special education program. Any child entering kindergarten must have a comprehensive health and developmental examination. Any student between the ages of three and 21 who is having school-related problems will be referred to the school's Administrator of Special Education to obtain all necessary assessments, including medical, psychological, and other specialty evaluations. Based on the results of these assessments, an individualized educational plan will be developed with an emphasis on meeting the needs of the child within the regular classroom setting. In addition, any problems that have been diagnosed must receive treatment.

(B) Payment. Many of the evaluation and treatment services required by the Special Education Law are reimbursable under the Medical Assistance Program. The Division cannot pay for services provided by school personnel. Any services not furnished by Medical Assistance providers, such as educational and social services, that are necessary for an eligible child's special education, will be furnished or arranged for by the local school agency, as required under Chapter 766.

(1) Individual Medical Assistance Providers. The Division will pay providers for services mandated by the Special Education Law that are furnished to children who are recipients. Payment will be based on the existing fee schedules. For example, the Division will pay for a complete physical examination as required by the law for a kindergarten-aged child if the child is referred to a pediatrician or health clinic that participates in the Medical Assistance Program. As required by the law, a provider who performs any assessments of eligible children after referral by an Administrator of Special Education must submit the reports to the local school agency. The provider must also take the responsibility for treatment of detected conditions.

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(2) Medical Assistance Core Evaluation Groups. The Division will pay, at a comprehensive rate, Division-approved interdisciplinary professional groups and Division-approved medical facilities that perform the medical, psychological, and family assessments of a Chapter 766 full core evaluation.

REGULATORY AUTHORITY

130 CMR 433.000: M.G.L. c. 18, § 10; M.G.L. c. 118E, § 4.

(PAGES 483 THROUGH 488 ARE RESERVED FOR FUTURE USE).

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(2) Once a physician has submitted a claim for PGH services, his name and address will appear on a PGH referral list to be used by the Division unless the physician notifies the Division's Medical Division either that he wants his name removed from the PGH referral list or that he no longer intends to provide PGH services.

(C) Disclosure Requirement. Recipients must be informed by the physician that information about their medical care will be furnished to the Division.

433.488: Project Good Health Services: Medical Protocol and Periodicity Schedule

Payment for PGH services is based upon the performance and documentation of the procedures listed in the Medical Protocol and Periodicity Schedule herein. The Schedule provides for basic preventive care and identifies recipients who require further diagnosis of suspected or actual health problems, treatment, or both. Explanations of procedures that appear in the Schedule and the information that must be maintained in the medical record to substantiate the performance of such procedures appear below.

(A) (Newborn) Initial History and Physical Examination -- documenting either in the physician's medical record or in the hospital chart an examination of the newborn in the hospital.

(B) (Newborn) Discharge History and Physical Examination -- documenting either in the physician's medical record or in the hospital chart the discharge history and physical examination of the newborn in the hospital.

(C) Health History -- recording in the medical record the family health history, baseline data on the recipient if not recorded previously, growth and development history, immunization history, known reactions to medications and allergies, pertinent information about previous illnesses and hospitalizations, drug, alcohol, and tobacco use, and other medical and psychosocial problems.

(D) Comprehensive Physical Examination -- documenting the findings, negative or positive, of an unclothed physical examination including:

(1) height, weight, and head-circumference measurements: head-circumference measurements are required until age one and recommended until age two. It is also recommended that measurements be plotted on appropriate growth charts;

(2) interval history: updating previously collected history in the medical record with any illnesses, diseases, or medical problems experienced by the recipient since the last visit;

(3) systems review, pertinent to the age of the recipient;

(4) gross vision and hearing screening up to age three, including the combined observations by the recipient's parent or guardian and physician of the recipient's response to sound and ability to follow moving objects visually;

(5) observation of the teeth and gums as appropriate; and

(6) other pertinent findings of the examination.

(E) Developmental Assessment -- the combined observations by the recipient's parent or guardian and by the physician of the recipient's current levels of functioning in the following areas, as appropriate to the recipient's age:

(1) gross motor development, including strength, balance, and locomotion;

(2) fine motor development, including hand-eye coordination;

(3) language development, including expression, comprehension, and articulation;

(4) self-help and self-care skills;

(5) cognitive skills, including problem-solving and reasoning abilities;

(6) sexual development, using a measure such as the Tanner scale; and

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(7). mental/emotional development, including the presence of learning disabilities, social integration and peer relations, psychological problems such as depression, and assessment of risk-taking behavior and school performance.

Documentation of developmental assessment may include descriptive observations, milestones, and/or the results of specific developmental screening tests such as the Denver Prescreening Developmental Questionnaire (PDQ), the Denver Developmental Screening Test (DDST), or the Early Language Milestone Scale (ELM). (PGH recommends referrals to early intervention programs for eligible children as defined by the Massachusetts Department of Public Health.)

(F) Nutritional Assessment -- the evaluation of the recipient's nutritional health, which includes history, diet history, physical examination, height, weight, head-circumference measurements, and laboratory tests. (PGH recommends that a referral be made to the Women, Infants, and Children program (WIC) for all eligible recipients.)

(G) Immunization Assessment/Administration -- the assessment of immunization status and administration of serums in accordance with the recommendations of the Massachusetts Department of Public Health and the American Academy of Pediatrics.

(H) Blood Pressure -- a standard procedure of the physical examination for recipients three years of age or older.

(I) Hearing Test -- screening by an audioscope or audiometric testing by an audiometer at the following frequencies: 500 Hz, 1000 Hz, 2000 Hz, and 4000 Hz. If the hearing test is performed in another setting such as a school, the test does not need to be repeated by the physician, but the test findings should be documented in the recipient's medical record.

(J) Vision Test -- testing by the Snellen chart, Titmus machine, or equivalent. Other tests, such as the Preschool Vision Screening System and the Broken Wheel, may be appropriate for preschool-aged children. If the vision test is performed in another setting such as a school, the test does not need to be repeated by the physician, but the test findings should be documented in the recipient's medical record.

(K) Health Education and Counseling -- educating and counseling the recipient, or his parent or guardian, in matters appropriate to the recipient's age (for example, nutrition, growth and development, tobacco and drug use, sexuality, AIDS, safety, and accident prevention).

(L) EP or Blood Lead Test -- the erythrocyte protoporphyrin method of testing for lead poisoning and iron deficiency, or other method as recommended by the Massachusetts Department of Public Health (DPH). It is recommended that children at increased risk receive more frequent screenings (for example, screenings every four to six months between the ages of nine months and three years or as recommended by DPH).

(M) Urinalysis -- the recommended urine screen, with or without microscopy.

(N) Urine Culture -- the recommended screening of preschool-aged females for asymptomatic bacteriuria. Routine cultures on males are not recommended unless indicated by history and/or examination.

(O) Tuberculin Test -- testing by the Tine or Mantoux (PPD). It is recommended that children at increased risk receive more frequent screenings (for example, screenings every three years after the four- to-six-year screening or as recommended by DPH).

(P) Cholesterol -- children over age two must be screened if their medical history indicates risk (that is, family history of heart attacks at an early age, coronary disease, lipidemia, diabetes, etc.).

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(Q) Sickle Cell -- this test is required if indicated by ethnicity. The Division recommends rescreening and education during adolescence as indicated.

(R) Pelvic Examination/Pap Smear -- these are recommended depending on the maturity level and sexual activity of the recipient. Documentation shall include both normal and abnormal findings for the initial pelvic examination and any abnormalities found thereafter. The Pap smear should be done at the time of the pelvic examination.

(S) Screens for Sexually Transmitted Diseases: Gonorrhea, Syphilis, Chlamydia, or Others -- tests should be performed for males and females depending on the maturity level, sexual activity, and/or abuse history of the recipient. If indicated, these may be done earlier than age 14.

(T) Dental/Fluoride Assessment -- the screening physician must encourage recipients to seek regular dental care, including biannual examinations, preventive services, and treatment, as necessary, from a dental provider, and must perform an assessment of systemic and topical fluoride on all children, newborn to age 21 years, as appropriate.

(U) Dental Referral -- the screening physician must refer recipients to a dental provider at age three, or earlier if indicated (such as when nursing-bottle syndrome is present).

433.489: Project Good Health Services: Description of Health Assessments

The health assessments described in 130 CMR 433.489 are reimbursable when provided by a physician or by a physician assistant under a physician's supervision.

(A) Initial Visit/Complete PGH Assessment. A physician may claim payment using Service Code 9021 for an initial visit, which consists of a complete PGH assessment in the provider's office for a new patient, or for a patient previously seen only for sick care (only once per recipient). A complete assessment includes the recording of family, medical, developmental, and immunization history; a systems review; a comprehensive physical examination; and appropriate screening as indicated in the PGH Medical Protocol and Periodicity Schedule.

(B) PGH Health Assessment. A physician may claim payment using Service Code 9020 for a PGH health assessment only if all the screening procedures in the Medical Protocol and Periodicity Schedule that correspond to the recipient's age have been performed. While the screening procedures are based upon a presumption of regular contact with health-care providers, many recipients have infrequent attention paid to their health-care needs and will need additional screening procedures to bring them up-to-date. In such a case, it is the physician's responsibility to furnish those additional screening procedures necessary to bring the recipient up-to-date with the recipient's preventive health care according to the Medical Protocol and Periodicity Schedule. The physician may make a screening referral to another provider if the physician is unequipped to perform a test (for example, if the physician does not have an audiometer and an audiometric test is required). However, in every case, all required screening procedures must have been performed and all results received in order for the physician to claim payment for a PGH health assessment.

(C) PGH Health Assessment with Special Circumstances. A physician may claim payment using Service Code 9022 for a PGH health assessment with special circumstances only in the following situations: a screening procedure has been omitted from the health assessment; or the results of laboratory tests or other referred screening procedures were not available within 30 days (see 130 CMR 433.489(C)(1) and (2)). The Division will individually review all claims for PGH health assessments with special circumstances to determine whether payment will be made. All claims for such health assessments based on the omission of a medically unnecessary screening procedure will be reviewed.

433.489: continued

(1) Omission of a Procedure. A physician may omit a procedure from a health assessment only in the following situations.

(a) Procedure Was Not Medically Necessary. If a physician omits a screening procedure from a PGH health assessment because, in the physician's professional judgment, the procedure is not medically necessary, the physician must indicate on the PGH claim form which procedure is omitted and why it is not necessary (see the billing instructions in Subchapter 5 of the *Physician Manual*). If a procedure is omitted because it was performed earlier, the date the procedure was performed must be included in the explanation and the results recorded in the recipient's medical record. If a procedure is omitted because it was performed in school, the results must be included in the explanation and recorded in the recipient's medical record. For the purposes of 130 CMR 433.489, nonperformance of a recommended procedure in the Medical Protocol and Periodicity Schedule is not considered an omission. Nonperformance of a required procedure is considered an omission.

(b) Procedure Was Impossible to Perform. If a physician omits a screening procedure from a PGH health assessment because it is impossible to perform, the physician must indicate on the PGH claim form which procedure is omitted and why it cannot be performed (see Subchapter 5 of the *Physician Manual*). If the procedure is impossible to perform because the recipient refuses to cooperate, the physician must describe in the explanation efforts made to overcome the recipient's resistance.

(2) Results of Laboratory Test or Referral Screening Procedure Not Available within 30 Days. If a physician does not know the results of a laboratory test or referred screening procedure within 30 days after the health assessment, the physician must indicate on the PGH claim form which laboratory or test results have not been received.

433.491: Project Good Health Services: Diagnosis and Treatment

(A) For any problem that requires further diagnosis or treatment after the health assessment, the physician must either request that the recipient return for another appointment as soon as possible or make a referral immediately (or as soon as the physician obtains the screening result indicating a need for referral).

(B) When making a referral to another provider, the screening physician must give to the recipient or to the recipient's parent or guardian the name and address of an appropriate provider.

(C) The screening physician must obtain a report of the results of diagnosis and treatment.

(D) If a physician knows of any reason that a recipient might not make or keep an appointment for further diagnosis and treatment, such as a need for transportation or translation, the physician may contact the PGH specialist in his area for assistance. PGH specialists are located in the local welfare offices.

433.492: Project Good Health Services: Claims for Health Assessments

(A) Fees for Health Assessments. The fees for the PGH health assessments in Subchapter 6 of the *Physician Manual* were adopted by the Massachusetts Rate Setting Commission for PGH health assessments furnished in accordance with the Medical Protocol and Periodicity Schedule and with these PGH regulations.

(B) Service Limitations. For each recipient from birth through nine years of age, a physician may claim only one health assessment per age level in the Medical Protocol and Periodicity Schedule. For each recipient aged ten years through 20 years, a physician may claim only one health assessment per year. Additional visits for high-risk recipients are not considered to be PGH health assessments but are reimbursable according to the office visit service codes and descriptions in Subchapter 6 of the *Physician Manual*.

433.492: continued

(C. Claims for Health Assessment of a Newborn. In order to be paid for a PGH health assessment of a newborn, the physician must have visited the newborn at least twice before the newborn leaves the hospital. The first visit, for an initial history and physical examination, is reimbursable as a hospital inpatient visit (see Subchapter 6 of the *Physician Manual*) and not as a PGH health assessment. The discharge visit, for a discharge history and physical examination, is reimbursable as a PGH health assessment, in accordance with 130 CMR 433.49289(D). Additional visits for ill newborns are reimbursable according to the hospital visit service codes in Subchapter 6 of the *Physician Manual*.

(D) Report Requirement. In order to claim payment for a PGH health assessment, a physician must submit a completed PGH claim form. The PGH claim form is specifically designed for recording whether each required test and screening procedure was provided, and for indicating problems needing follow-up treatment. Instructions for obtaining and completing the PGH claim form are in Subchapter 5 of the *Physician Manual*.

(1) When submitting a claim for a health assessment with special circumstances, the physician must explain the special circumstances on the PGH claim form (see 130 CMR 433.489(C)).

(2) If a nurse practitioner or physician assistant has performed the health assessment, this must be indicated on the PGH claim form.

433.493: Project Good Health Services: Claims for Laboratory Services

The following laboratory services, which are included in the Medical Protocol and Periodicity Schedule, are reimbursable in addition to the health assessment when they are performed in the office of the physician who furnished the health assessment. A physician may not claim payment for any test until the results are known.

Service Code	Service Description
822310	Beta-2 microglobulin, urine; RIA
822320	Beta-2 microglobulin, serum; RIA
850180	Blood count; hemoglobin
850140	Blood count; hematocrit
862560	Chlamydia (fluorescent antibody; titer)
824650	Cholesterol, serum, total
870810	Culture, bacterial; screening only, for single organisms
871100	Culture, chlamydia (I.C.)
881500	Cytopathology, smears, cervical or vaginal (e.g., Papanicolaou); up to 3 smears; screening by technician under physician supervision
108379	Erythrocyte protoporphyrin; mailing of specimen to Department of Public Health
836550	Lead, blood; quantitative
836600	Lead, urine; quantitative
847030	Pregnancy test (gonadotropin, chorionic; qualitative)

433.493: continued

Service Code	Service Description
847020	Pregnancy test (gonadotropin, chorionic; quantitative)
872100	Smear, primary source, with interpretation; wet mount with simple stain, for bacteria, fungi, ova and/or parasites
865920	Syphilis; precipitation or flocculation tests, qualitative (VDRL, RPR, ART)
856600	Sickling of RBC; reduction, slide method
844780	Triglycerides, blood
810000	Urinalysis, routine (pH, specific gravity, protein, tests for reducing substances as glucose); with microscopy
810020	Urinalysis, routine; without microscopy

433.494: Project Good Health Services: Claims for Audiometric Hearing and Titmus Vision Tests

Payment for the audiometric hearing test and the Titmus vision test, which are both included in the Medical Protocol and Periodicity Schedule, is not included in the fee for a health assessment and should be claimed separately according to the service codes in Subchapter 6 of the *Physician Manual*.

433.495: Project Good Health Services: Recordkeeping Requirements

(A) Medical Records. A physician must create and maintain a centralized record for every PGH recipient in his care, in accordance with Division regulations governing medical records (see 130 CMR 433.409). In addition, the record for each PGH recipient must contain documentation of the screening procedures listed in 130 CMR 433.488(A) through (U) as well as the following:

(1) the results of all laboratory tests;
(2) the name and address of each referral provider; and
(3) the date and results of each referral appointment, if the appointment was kept.

(B) Determination of Compliance with Medical Standards. The Division may review a physician's medical records of PGH recipients to determine the necessity, propriety, and quality of the medical care furnished. These determinations will be made by medical professionals in accordance with 130 CMR 450.206. In addition, the Division may request review by the Massachusetts Chapter of the American Academy of Pediatrics, or other appropriate professional organization, for the purposes of making such determinations. This review will be considered before the Division proceeds with administrative action based on a determination of noncompliance with medical standards as defined in 130 CMR 450.204.

REGULATORY AUTHORITY

130 CMR 433.000: M.G.L. c. 18, § 10; M.G.L. c. 118E, § 4.

TN 97-14
STATE PLAN AMENDMENT
INPATIENT ACUTE HOSPITAL

EXHIBIT 5: 114.1 CMR 36.07(3)(c) and (d)

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